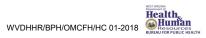
Screen DateEa		Early and Periodic S	West Virginia Department of Health and Human Resources Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen						
Name					DOB		Age_	Sex: 🗆 M 🗆	
Weight	Length	Weight for Length	HC	Pulse	BP (optional)	Resp	Temp	Pulse Ox (optional)	
Allergies □ N	KDA								
Current meds	□ None								
☐ Foster child	l			Child v	with special health care needs_				
Accompanied	by □ Parent □ G	Grandparent □ Foster parent □ F	oster organizati	on			Other		
Medical History ☐ Initial screen ☐ Periodic screen Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:			Maternal Depression/Patient Health Questionnaire (PHQ-2) *Positive screen = numbered responses 3 or greater *If Positive see Periodicity Schedule for link to Edinburgh Postnatal Depression Scale (EPDS) Feelings over the past 2 weeks: (✓ Check one for each question) Little interest or pleasure in doing things □ Not at all □ Several days(1) □ More than ½ the days(2)		Child exp ☐ Drugs ☐ Access Are the fil	Risk Indicators (✓ Check those that apply) Child exposed to □ Cigarettes □ E-Cigarettes □ Alcohol □ Drugs (prescription or otherwise) □ Access to firearm(s)/weapon(s) Are the firearm(s)/weapon(s) secured? □ Yes □ No □ NA General Health □ Growth plotted on growth chart			
☐ Family health history reviewed			□ Nearly every day(3) Feeling down, depressed, or hopeless □ Not at all □ Several days(1) □ More than ½ the days(2) □ Nearly every day(3) Concerns and/or questions						
Concerns and/or questions							Do you think your child sees okay? ☐ Yes ☐ No Do you think your child hears okay? ☐ Yes ☐ No		
Social/Psychosocial History What is your family's living situation?							ıption ☐ Yes ☐ No		
Family relationships □ Good □ Okay □ Poor Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? □ Yes □ No			Developmental Developmental Surveillance (✓ Check those that apply)			Water sou Fluoride s Fluoride v	Current oral health problems		
	Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No		Social Language and Self-help □ Child can pat or smile at his/her reflection □ Child can look when you call his/her name Verbal Language (Expressive and Receptive) □ Child can babble			Nutrition □ Breast	Nutrition/Sleep □ Breast feeding; Frequency		
Who do you contact for help and/or support?		☐ Child can make sounds like "ga", "ma", or "ba" Gross Motor ☐ Child can roll over from back to stomach ☐ Child			☐ Bottle f	☐ Bottle feeding; AmountFrequency			
Child careChild has abilit	Are you and/or your partner working outside home?		can sit briefly without support Fine Motor □ Child can pass a toy from one hand to another □ Child can rake small objects with 4 fingers □ Child can bang smal objects on surface Concerns and/or questions		□ Juice □ Has sta □ Witamir □ Norma	☐ Juice ☐ Water			
□ None □ Slight □ Moderate □ Severe What kind of stress? (✓ Check those that apply)						— □ Place o	on back to sleeps and/or questions		

☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health

insurance ☐ Other

Continue on page 2



Screen	Data		
oci ee ii	Date		

Name_

Age_

Sex: □ M □ F

*See Periodicity Sch	edule for Risk Factors	Anticipatory Guidance	Plan of Care Assessment □ Well Child □ Other Diagnosis Immunizations □ UTD □ Given, see immunization record □ Entered into WVSIIS Labs		
*Lead Risk □ Low risk □ High	risk	(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)			
*Tuberculosis Risk □ Low risk □ High	risk	Social Determinants of Health Living situation and food security			
•	ation (N=Normal, Abn=Abnormal)	☐ Tobacco, alcohol, and drugs ☐ Parental depression			
Skin	□ N □ Abn	☐ Family relationships and support☐ Child care	☐ Blood lead (if high risk) (enter into WVSIIS) ☐ TB skin test (if high risk) ☐ Other		
Neurological Reflexes Head	□ N □ Abn	Infant Behavior and Development ☐ Parents as teachers			
Fontanelles Neck	□ N □ Abn	☐ Community and early literacy ☐ Media			
Eyes Red Reflex Ocular Alignment	□ N □ Abn □ N □ Abn □ N □ Abn	☐ Emerging infant independence ☐ Putting self to sleep ☐ Self-calming	Referrals ☐ Maternal depression-Help4WV.com/1-844-435-7498 ☐ Developmental ☐ Other		
Ears Nose Oral Cavity/Throat Lung	□ N □ Abn	Oral Health □ Fluoride, oral hygiene/soft toothbrush, avoidance of bottle in bed	☐ Right from the Start (RFTS) 1-800-642-9704 ☐ Birth to Three (BTT) 1-800-642-9704 ☐ Oblide The Start (RFTS) 1-800-642-9704		
Heart Pulses Abdomen	□ N □ Abn □ N □ Abn □ N □ Abn □ N □ Abn	General quidance on feeding	☐ Children with Special HealthCare Needs (CSHCN) 1-800-642-9704 ☐ Women, Infants and Children (WIC) 1-304-558-0030		
Genitalia Back Hips	□ N □ Abn	☐ Posticides in vegetables and fruits	Prior Authorizations For treatment plans requiring authorization, please complete		
Extremities	□ N □ Abn	☐ Formula-feeding guidance Safety	page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck		
Signs of Abuse Concerns and/or ques	☐ Yes ☐ No stions	☐ Car safety seats ☐ Safe sleep ☐ Safe home environment (burns, sun exposure, choking, poisoning, drowning, falls)	Follow Up/Next Visit □ 9 months of age □ Other		
		□ Other	☐ Screen has been reviewed and is complete		
			Please Print Name of Facility or Clinician		
			Signature of Clinician/Title		

DOB_